Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SURGERY CENTER OF LEWISVILLE
1854 LAKE POINTE DRIVE
LEWISVILLE TX 75057

Respondent Name

WAL MART ASSOCIATES INC

Carrier's Austin Representative Box

Box Number 53

MFDR Tracking Number

M4-11-1551-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was partially denied by the carrier stating that unpaid CPT 29826 & CPT 29822 are included in the paid procedure CPT 29806. We are disputing that fact. According to the Medicare National Correct Coding initiative none of the procedures on this claim are included or bundled with one another."

Amount in Dispute: $3,590.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider's correspondence statement that 'none of the procedures on this claim are included or bundled with one another' is incorrect. 29822 & 29826 are column 2 codes to 29806 indicating these ARE bundled. SEE PROVIDER'S SUBMITTED COPY OF MEDICARE NCCI EDITS FROM CMS.GOV.

- NOTE: MODIFIER STATUS OF '1'. This status indicates that a MODIFIER MAY BE ALLOWED TO BYPASS THE EDIT, IF THE MODIFIER IS DOCUMENTED. This status does NOT indicate that the CODE is allowed, as possibly interpreted by provider."

"NCCI Outpatient Edits were correctly applied to this bill, with denial of reimbursement of 29822 & 29826, as column 2 codes to 29806 in this operative session."

"Modifier 59 has been misused with CPT 29822 & 29826 on this bill; conflicts with NCCI guidelines. 29822 & 29826 both have a modifier status of '1', which indicates the two does of the code pair edit may be reported if performed on the CONTRALATERAL organ or structure; these code pairs should not be reported with NCCI-associated modifiers when performed on the ipsilateral organ or structure (as in this case)."

"Per NCCI, if an edit allows use of NCCI-associated modifiers, the two procedure codes may be reported together, IF THE TWO PROCEDURES ARE PERFORMED AT DIFFERENT ANAOTMIC SITES OR DIFFERENT PATIENT ENCOUNTERS."

"PER NCCI GENERAL CODING PRINCIPLES, ARTHROSCOPIC TREATMENT OF A SHOULDER INJURY IN ADJOINING AREAS OF THE IPSILATERAL SHOULDER CONSTITUTES TREATMENT OF A SINGLE ANATOMIC SITE."

All procedures in this operative session performed on RIGHT shoulder, in single operative session, with exact descriptions, on which NCCI Edits are based. In accordance, modifier 59 exception is not warranted. 0/08/2010 charges have been correctly reimbursed; no additional payment due to provider."

Response Submitted by: Hoffman Kelley on behalf of Wal-Mart Associates Inc., 5316 Hwy. 290 West, Suite 360, Austin, TX 78735.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2010	ASC Services for code 29806	$0.01	$0.00
	ASC Services for code 29826-59	$2,226.37	$0.00
	ASC Services for code 29822-59	$1,364.53	$0.00
TOTAL		$3,590.91	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 20, 2010 and October 21, 2010
   - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 899-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor) component codes of comprehensive surgery; musculoskeletal system procedure (20000-29999) has been disallowed.
   - 983-Charge for this procedure exceeds Medicare ASC schedule allowance.
   - W1-Workers Compensation state fee schedule adjustment.
   - 5036-Complex bill-reviewed by Medical Cost Analysis Team.

   Explanation of benefits dated November 23, 2010
   - W1-Workers Compensation state fee schedule adjustment.
   - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 899-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor) component codes of comprehensive surgery; musculoskeletal system procedure (20000-29999) has been disallowed.
   - 983-Charge for this procedure exceeds Medicare ASC schedule allowance.
   - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - 5036-Complex bill-reviewed by Medical Cost Analysis Team.

Issues

1. Did the requestor support position that additional reimbursement is due for ASC services for code 29806? Is the requestor entitled to reimbursement?
2. Did the requestor support position that 29826-59 is not global to code 29806-59? Is the requestor entitled to reimbursement?

3. Did the requestor support position that 29822-59 is not global to code 29806? Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

   Based upon the submitted EOBs, the respondent paid HCPCS code 29806 based upon reason codes "W1" and "983".

   HCPCS code 29806 is defined as "Arthroscopy, shoulder, surgical; capsulorrhaphy"

   28 Texas Administrative Code §134.402(f) reimbursement for non-device intensive procedure for HCPCS code 29806 is:
   The Medicare ASC reimbursement rate is found in the Addendum AA ASC Covered Surgical Procedures.
   The ASC fully implemented relative payment weight for CY 2010 = 45.5859.
   This number is multiplied by the 2010 Medicare ASC conversion factor of 45.5859 X $41.873 = $1,908.81.
   The Medicare fully implemented ASC reimbursement rate is divided by 2 = $954.40 ($1,908.81/2).

   This number X City Conversion Factor/CMS Wage Index for Lewisville, Texas is $954.40 X 0.9841 = $940.37.

   The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted reimbursement $954.40 + $940.37 = $1,894.77.

   Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $1,894.77 X 235% = $4,452.70.

   The MAR for HCPCS code 29806 is $4,452.70. The insurance carrier paid $4,452.75. As a result, additional reimbursement is not recommended.

2. Based upon the submitted EOBs, the respondent denied reimbursement for HCPCS code 29826-59 based upon reason codes "97", and "899".

   HCPCS code 29826-59 is defined as "Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)."

   Per National Correct Coding Initiatives, HCPCS code 29826 and 29806 are comprehensive codes and are typically not billed separately; however a modifier is allowed to designate a difference service.

   The requestor added modifier "-59" to HCPCS code 29826.

   Modifier 59 - Distinct Procedural Service is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

   A review of the operative report indicates that the claimant underwent the following procedures: 1) Right shoulder arthroscopy with anterior labral repair; 2) Right shoulder subacromial decompression with removal of roughly anterior 3 mm of bone; and 3) Extensive debridement of anterior labrum, superior labrum, partial cuff tear."

The Division finds that the requestor did not support the use of modifier "-59" as a distinct procedural service. The requestor did not support that HCPCS code 29826 is not global to 29806. Therefore, reimbursement is not recommended.

3. Based upon the submitted EOBs, the respondent denied reimbursement for HCPCS code 29822-59 based upon reason codes "97", and "899".

   HCPCS code 29822-59 is defined as "Arthroscopy, shoulder, surgical; debridement, limited."

   Per National Correct Coding Initiatives, HCPCS code 29822 and 29806 are comprehensive codes and are typically not billed separately; however a modifier is allowed to designate a difference service.

   The requestor added modifier "-59" to HCPCS code 29822.

   The Division finds that the requestor did not support the use of modifier "-59" as a distinct procedural service. The requestor did not support that HCPCS code 29822 is not global to 29806. Therefore, reimbursement is not recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, the Division concludes that the requestor has not supported its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	2/7/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.